8/9/10

Although I still have much to learn, I think I have a better idea of what research “styles” or methodological approaches we each bring, the questions we propose to answer, and the types of data we propose using. Those all need to be fleshed out, of course, but what I think we are struggling with (besides understanding each other) is the interdependence among approaches, data, and (in the back of our minds) grants in addressing the questions. Issues of quality, for example, can’t be address well using only one method, using one data source, led by one person, under one grant. Identifying what people on the ground have to say about quality studied through qualitative interviews would be informative. Analyzing facility data is useful and very inexpensive per observation but very imperfect in its measures. MDS and use-based measures from claims are better and have the virtue of long panels for estimating impacts, but are more expensive and are still imperfect quality indicators. Primary collection of extensive quality measures improves on the measure for cross section analysis but lacks pretest measures important for estimating impacts. Surveys measuring quality of life would provide another important outcome for Green Houses in addition to quality of care for cross section analysis.

In the table below, I tried to summarize the questions, data, and methods we have talked about and take a first cut at indicating the interdependence among the them. Please cut me slack if I have mischaracterized questions, methods, or data, and educate us as needed. I would like to discuss this on our next call.

Data sources:

*Facility data*: OSCAR, CMS Cost Reports, NH Compare, Brown LTCfocusUS data, etc. (e.g., what Amy used in her paper)

*Pioneer Survey*: Planned Pioneer survey on elements of culture change adopted broadened to include GreenHouse and comparison homes with hoped-for Commonwealth funding

*Qualitative interviews*: In-depth, semi-structured interviews with informants at all levels conducted on site visits (or potentially by telephone), probably transcribed for analysis (e.g., what Barbara and Kim collected in the Green House paper); potentially focus groups

*Quantitative organization data*: Measures of structure, process, outcomes, and other organization-level and individual-level data collected or extracted from existing records (e.g., what Susan and Siobhan have collected in the past).

*Surveys*: Primary survey data (e.g., internet, telephone) using closed ended questions.

*MDS* data at individual level

*Claims*: Medicare and possibly Medicaid data

Table. Potential methods and data that could be used to address evaluation questions

| Evaluation question | Quantitative descriptive analyses[[1]](#endnote-1) | Grounded dimensional analysis[[2]](#endnote-2) | Multivariate analysis of cross-section data[[3]](#endnote-3) | Impact analysis using pre-post, matched comparison group design[[4]](#endnote-4) |
| --- | --- | --- | --- | --- |
| What is the impact of GH/culture change on quality of care? |  | Qualitative data |  | 1. Facility data  2. MDS data  3. Use-based measures from claims |
| What is the impact of GH/culture change on cost? |  |  |  | 1. CMS cost reports  2. Claims data |
| Who adopts GH/culture change? | 1. Facility data  2. Pioneer survey | Qualitative data |  | 1. Facility data  2. Pioneer survey  [3. MDS data]  [4. Claims data] |
| What are the essential elements of GH/culture change? | Pioneer survey | Qualitative data |  |  |
| What structure, process, and other factors associated with outcomes? |  | Qualitative data | 1. Quantitative organization data  2. Facility data, MDS, or use-based measures combined with Pioneer survey  3. Surveys (e.g., quality of life) combined with Pioneer survey |  |
| What is necessary to assure that essential elements are in place? |  | Qualitative data | 1. Pioneer survey combined with facility data  2. Pioneer survey combined with surveys  3. Quantitative organization data |  |

1. I am thinking of means, graphs, distributions, crosstab, etc. analyses that describe any variety of things. [↑](#endnote-ref-1)
2. I am thinking of the style of analysis that Barbara has done and that typically collects intensive data (through site visits or sometimes phone interviews) at a relatively small number of organizations. It also could include other intensive data collection and analysis, like Siobhan’s work study describing and comparing how staff spend their time with crosstab analysis. Although the analysis is quantitative, it requires intensive data collection and is informed heavily by what was learned on site. [↑](#endnote-ref-2)
3. Although I realize that their approaches differ in a number of ways, e.g., in type of data collection and how to decide what factors to emphasize, I am thinking of the final stage of Susan/Siobhan’s practice-based studies and Sheryl’s assisted living study relating outcomes to the structure and process of care. That is, multivariate analysis of moderate size, cross-section samples of residents clustered within facilities relating outcomes to a rich set of organizational, structure, and process factors and using case-mix adjustment.

   [↑](#endnote-ref-3)
4. I am thinking of the methods often used by economists, including David, and evaluation types like myself. Amy’s paper is an excellent example applied to culture change. After defining a comparison group (or groups in our case) that is important for policy and practice, a comparison sample is defined by matching organizations or individuals to the treatment group using propensity score methods. It uses panel data to conduct a “difference-in-difference” type analysis (akin to a pretest-post non equivalent comparison group design), typically with fixed effects for organizations and calendar time, to estimate effects (i.e., “impacts”) of the “intervention.” [↑](#endnote-ref-4)